k. Home health care services for any individual who is eligible under this plan to receive skilled nursing home care; provided such care is recommended in writing by a licensed physician and that the individual is certified by a Division of Welfare staff physician as medically requiring such care. Home health care services may be provided by home health agencies with which an agreement with the Division of Welfare is in effect and which are certified for participation in Title XVIII. Home health care services shall be provided on an intermittant or part-time basis and shall be limited to nursing services provided by a home health agency or, when no home health agency is available, provided under the direction of the patient's physician by a registered nurse or a licensed practical nurse with whom an agreement with the Division of Welfare is in effect. Home health care services may be provided in the individual's place of residence, but not including as a residence a hospital, an extended care facility, a skilled nursing home, or any governmental hospital.

l. Optometric services, effective October 13, 1972, limited to one visual examination and refraction each twelve months.

m. Family planning services as defined by Federal rules and regulations, but not including abortions unless medically indicated.

2. These services will be provided effective November 1, 1967, except as otherwise noted.

3. Medical and remedial care and services will be uniform in amount, duration, and scope for all categorically needy individuals (as defined in III-A). Except that as specified in Item 1, above: (a) services to persons in state institutions for tuberculosis or mental diseases are limited to persons 65 years of age or over, and (d) skilled nursing home services are limited to persons 21 years of age or older. Services covered by XVIII B which are not included in IV-A-1-a-g will not be available to cash recipients under 65 years of age.

4. Criteria to assure high quality of the care and services provided under the Plan include the following:

a. Provision is made for use of specialist and consultative medical service.

b. Provision is made for necessary transportation of recipients to and from the suppliers of medical and remedial care and services through the cash grant. There is a basic standard of $6.00 per month per assistance group for transportation cost for the purpose of shopping, attending church, and obtaining medical care. This monthly allowance is equivalent to 60 miles per month by automobile at $ .10 per mile. In many locations private organizations, such as churches, Red Cross, and other volunteers will provide transportation for the purpose of obtaining medical care. CEO projects also provide transportation in several locations.

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c. Priority is given to the use of available semi-private accommodations (as defined in Section 1861 (v)(4) of the Social Security Act) for hospitalized recipients.

d. Long-term care of patients in medical institutions is provided in accordance with procedures and practices that include the following:

(1) Care is authorized only on recommendation by a physician and after joint consideration by the physician and the social worker of the pertinent medical and social factors, including consideration of alternative arrangements for the patient's care.

(2) There is a medical-social plan for each patient which includes consideration of alternative types of care and which is reassessed periodically.

(3) In making placements, the record is precise as to the medical reason for admission. It shows what alternative methods, such as family care home, social care institution, home health aide, homemaker, etc., have been considered by the admitting physician and the caseworker and specifies the medical-social plan of treatment for the individual.

(4) Each patient is under the care of a physician who has responsibility for continued medical care and planning for that patient, and who visits him at least once a month.

(5) There is a periodic review of the care, treatment and plan for each patient by a physician, nurse and social worker, acting as a team.

(6) In addition to the clinical record maintained by the facility, there is a continuing case record in the agency, including the items specified above; and

(a) regular notes of agency contacts with the patient, with his relatives, with the physician, and with the nursing home;

(b) notations regarding the patient's progress; and

(c) information regarding problems that have arisen related to his care, and action taken with respect to them.

(7) Arrangements are made with the state standard-setting authority to certify to the state Title XIX agency whether facilities qualify under the definition of skilled nursing home set forth in SRS Program Regulations 40-11 and 40-12.

e. Standards for medical and remedial care and services incorporate, as appropriate, standards in other specialized, high quality programs, particularly the program of crippled children's services.

f. In the provision of drugs,

(1) The state uses professional pharmaceutical consultation;

(2) Standards and procedures provide for dispensing of drugs at the lowest cost consistent with quality; and

(3) There is review and analysis of drug bills, including the compilation of statistics with respect to types, quantities, and cost of drugs dispensed.

g. There is a specific plan for a continuous evaluation of the utilization and quality of medical and remedial care and services provided under the State Plan.

(1) Prescription Drugs. A 30-day limitation has been established on the quantity of drugs that might be issued on any one prescription. Payment is further limited to drugs obtained on the original prescription and six refills (except for drug abuse items where Federal Regulations apply) however, not to exceed six months. After the 6th refill, a new prescription must be written. Detailed statistics are kept on drug claims by the quantity of each drug used in each given month. Our computer is programmed to reject claims that indicate an excessive quantity of a given drug. These claims are then reviewed by one of our three pharmacists. The pharmacist may request additional information from the vendor in the form of the original copy of the prescription or whatever information seems to be appropriate. All questionable claims are reviewed by one of our three registered pharmacists. One of our registered pharmacists spends full time on the road visiting the various drug stores and dispensing physicians who participate in the program. This pharmacist reviews prescription files and checks them against the claims filed by the vendors. This is done on a random sample basis and he also checks any questionable claims from the pharmacist or dispensing physicians. In addition to this, he assists the drug stores and dispensing physicians with any question they might have about the Welfare Drug Program or the way they should keep records for the program.

(2) Physicians Services. Two full-time licensed physicians are employed in the Bureau of Medical Services and they review any claim for physicians services on which there is any question of utilization. This may be the number of services or the frequency with which the services are provided. Under certain circumstances we will review claims submitted by individual physicians over the course of one or more months. This enables the reviewing physician to detect any unusual pattern of utilization. If questions arise, the physician providing the service is contacted on the telephone by one of our staff physicians here in the Bureau of Medical Services. The Missouri State Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons have developed committees within each of the specialties and for the general practitioner. These committees have agreed to review and comment upon claims submitted under the Title XIX Program where it appears the physician is over-utilizing or engaging in some questionable practice.

(3) Inpatient Hospital Care. Our program requires that each participating hospital have a utilization review plan which applies to Title XIX cases the same way it applies to Title XVIII cases. We have further reserved the right to review the medical information on any length of stay in excess of 14 days. We routinely request utilization review findings and medical information on any length of stay in excess of 30 days. This information is then examined by one of our staff physicians and a decision reached. The Division of Health Section of Medical Care certifies hospitals and extended care facilities for the Title XVIII Program. We have an agreement whereby the Division of Health Section of Medical Care performs the utilization review function and medical audit for these institutions and professional nursing homes.

(4) Outpatient Hospital Care. This same general procedure is used for outpatient care as for physicians services.

(5) Dental Care. Claims for dental services are reviewed by one of two part-time dental consultants employed by the agency. We require pre-operative and post-operative x-rays on any operative work in excess of $20. We further require x-rays when four or more extractions are performed at one setting. In the case of partial dentures, we also require x-rays. Under certain circumstances we review a block of claims submitted by an individual dentist in order to assure that utilization is within reason. Our listing of services is specifically devised to help us avoid some of the more obvious areas where over-utilization might occur. We do require prior authorization on a number of services including full or partial dentures for this purpose.

(6) Skilled Nursing Home Care. Medical necessity for skilled nursing home care is certified by having the medical summary and social information reviewed by one of our consulting physicians in the State Office who sets a re-review date if the patient is certified. We reserve the right to re-examine the certification of any skilled nursing home patient when the county or other sources of information indicates the need for such re-examination.

(7) Laboratories and X-ray Services. These claims are reviewed in the same manner as those claims filed for physicians services.

(8) Optometric Services. Service must be provided by a currently licensed optometrist and is limited to visual examination and refraction no more than once each twelve months. Controls are established to enforce these limits and to control utilization.

h. Methods exist that assure that direct service workers and their supervisors are knowledgeable about health problems and ways to assist people to secure medical and remedial care and services.

i. Direct service workers are kept currently informed of significant medical information concerning their clients.

j. As family planning drugs and services are provided, there shall be freedom from coercion or pressure of mind and conscience and freedom of choice of method, so that individuals can choose in accordance with the dictates of their consciences.

5. The state agency will provide for broadening the scope of the medical and remedial care and services made available under the Plan, to the end that, by July 1, 1977, comprehensive medical and remedial care and services will be furnished to all eligible individuals.

B. Assistance to Aged Individuals in Institutions for Mental Diseases (D-5200)

1. Medical assistance is provided in behalf of eligible individuals (as specified in III A) age 65 and over who are patients in institutions for mental diseases operated by the Missouri State Division of Mental Health when such mental institution is certified to participate in Title XVIII as a psychiatric hospital.

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5. Determination of reasonable charges.

a. Outpatient Drugs: Our established charges for drug vendor prescriptions are based on cost of acquisition plus a professional fee of $1.00 plus 10 cents to cover the cost of the container. We have determined the cost of acquisition to be the published cost to the retailer from the supplier.

Since we operate on a limited formulary as opposed to an open formulary, we have deemed it necessary to establish the charges we will allow. Some of these charges are based on costs direct from manufacturers, while others are based on costs from wholesalers. This determination is made by our staff of three registered pharmacists. In arriving at these prices such items as the popularity of the drug statewide and minimum requirements as set by the manufacturer are taken into consideration. The same determinant is used in resolving the quantity cost on which the price shall be based.

Monthly reports on the usage of each drug will be reviewed, and from this review we are in a position to evaluate our pricing schedule. The allowable charges are subject to change accordingly. A majority of these prices as set forth in Regulation 124 are based on the cost per smallest unit. It should be further stated that we have established a 30-day limitation on the quantity of drugs that might be issued on any one prescription. In extenuating circumstances we do permit up to a 90-day quantity but we do not do this, however, with out a note from the vendor either by our request or submitted with the claim.

b. Physicians Services: Under the Missouri Title XIX Law, determination of reasonable charge is to be at the discretion of the Missouri Division of Welfare. It is the desire of the Division of Welfare to provide reimbursement for the physician's charge as billed if the charge falls within a range of charges considered as "reasonable".

With the help of the Missouri State Medical Association and the Missouri State Osteopathic Association, cut-off limits for the various procedures were originally established. Recommendations were submitted by all specialty groups for the most commonly used procedures in their specialty. These recommendations were reviewed and adapted where necessary to provide consistency in reimbursement for all types of services. Determinations on a reasonable charge are continually under review. This review is handled by the Title XIX administrative and medical staff, and when a fee previously established is shown to be out of line with apparently similar procedures, the cut-off limit is revised accordingly. To protect against random changes in the maximum cut-off limits, a change is approved only after extensive deliberations with the Medical Consultants, the Supervisor of Medical Claims Payments, the Chief of the Bureau of Medical Services, the Director of the Division of Welfare, and such members of the Medical Advisory Committee as are appropriate.

Physician profiles will be utilized as soon as they are made available to the State Agency by SSA or the Title XVIII Carriers.

Attachment 8

CODE	SURGICAL DESCRIPTION	KANSAS CITY MEDICARE	GENERAL AMERICAN MEDICARE	MISSOURI DIVISION OF WELFARE
	Drainage of infected steatoma	$40.00	$16.00	$ 9.00
0103	Drainage of small subcutaneous abcess	$30.00	$22.00	$ 9.00
0125	Drainage of onychia or paronychia with or without complete or partial evulsion of nail	$25.00	$14.00	$ 9.00
0140	Drainage of hematoma	$25.00	NA	$ 9.00
0178	Local excision of small benign neoplastic, cicatricial, inflamatory or congenital lesion, one	$15.00	$34.00	$20.00
0230	Excision of nail, nail bed or nail fold	$35.00	$78.00	$40.00
0401	Cauterization or fulguration of benign lesion, single, small	$15.00	$63.00	$13.00
	Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion or nipple (including any other partial mastectomy), unilateral	$125.00	$127.00	$60.00
0501	Aspiration biopsy of bone marrow, including sternal puncture	$35.00	$26.00	$13.00
0740	Fracture, clavicle, simple, closed reduction	$75.00	NA	$30.00
0806	Colles' fracture, immobilization only	$75.00	$138.00	$40.00
0807	Colles' fracture, closed reduction	$125.00	$138.00	$60.00
0821	Fracture, radius and ulna shafts, closed reduction	$150.00	$135.00	$80.00
0851	Fracture, phalanx or phalanges, one finger or thumb, immobilization only	$35.00	NA	$10.00

0852	Closed reduction	$50.00	NA	$30.00
[illegible]	Fracture, metatarsal, simple one, closed reduction	$75.00	NA	$40.00
[illegible]	Fracture, phalanx or phalanges, one toe, closed reduction	$35.00	NA	$13.00
1046	Arthrocentesis: puncture for aspiration of joint	$20.00	NA	$15.00
1074	Laminectomy for removal of intervertebral disc, lumbar	$600.00	NA	$350.00
1075	Laminectomy with spinal fusion (one surgeon)	$750.00	NA	$400.00
2111	Bronchoscopy	$75.00	$97.00	$60.00
2450	Office procedure, intravenous injection	$15.00	NA	NA
3051	Esophagoscopy	$100.00	$106.00	$50.00
3121	Gastroscopy	$75.00	$106.00	$40.00
[illegible]	Colectomy, partial, with anastomosis and with or without proximal colostomy and its closure	$500.00	$642.00	$300.00
3261	Appendectomy	$250.00	$272.00	$175.00
3311	Sigmodoscopy	$25.00	$22.00	$20.00
3380	Hemorrhoidectomy, internal and external	$200.00	$172.00	$125.00
3515	Cholecystectomy	$350.00	$419.00	$275.00
3571	Exploratory laparotomy; exploratory celiotomy	$300.00	$316.00	$160.00
3631	Hernia, inguinal, unilateral	$200.00	$262.00	$160.00
3638	Hernia, inquinal, bilateral	$300.00	NA	$240.00
3931	Cystoscopy, complete, including catheterization of the ureters and/or retrograde pyclogram	$85.00	$30.00	$60.00

3932	Cystoscopy, simple bladder	$50.00	$34.00	$35.00
4	Dilation of filiform urethral structure by passage of filiform and follower	$15.00	$16.00	NA
4033	Subsequent	$20.00	$10.00	NA
4252	Vasectomy, complete or partial or ligation of vas, bilateral	$125.00	$131.00	$60.00
4321	Transurethral resection of prostate, one or more stages	$400.00	$451.00	$300.00
4617	Hysterectomy: total hysterectomy (corpus and cervix) with dilation and curettage under same, anesthesia, and with or without surgery on tubes, ovaries, ligaments, etc.	$400.00	$440.00	$250.00
4631	Vaginal Hysterectomy, with or without pelvic floor repair	$400.00	$385.00	$240.00
4641	Local excision of lesion of cervix (cauterization or electroconization)	$35.00	$24.00	$13.00
4	Cold conization	$125.00	NA	NA
4644	Local excision of lesion of cervix in conjunction with dilation and curettage	$125.00	$155.00	$60.00
4650	Dilation and curettage of uterus for all other causes except removal of uterine polyps, miscarriage or abortion and post partum hemorrhage, including diagnosis	$125.00	$132.00	$75.00
1-9002	Initial visit with comprehensive history and physical	$35.00	$29.00	$13.00
1-9004	Follow-up visit, routine	$ 8.00	$11.00	$ 6.00
1-9005	Follow-up visit necessitating care over and above routine	$12.00	$12.00	$10.00

1-9008	Complete re-examination or re-evaluation	$25.00	NA	NA
14	Follow-up home visit, routine	$15.00	NA	$ 7.00
1-9017	Injection	$15.00	NA	$ 3.00
1-9018	Physical Therapy, per treatment	$15.00	$ 5.00	$ 7.00
1-9020	Initial visit with comprehensive history and physical exam	$45.00	$21.00	$20.00
1-9024	Follow-up visit - routine hospital call	$10.00	$10.00	$ 6.00
1-9028	Consulation requiring limited examination of a given system but not necessitating a complete diagnostic history and examination	$30.00	$24.00	$13.00
1-9030	Consultation requiring complete diagnostic history and examination and/or treatment	$50.00	$60.00	$22.00

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